Canadian Mental Health Association
Huron Perth Addiction and Mental Health Services

Client Information Package

At Canadian Mental Health Association Huron Perth Addiction and Mental Health Services, we support positive change in individuals, families and the community by delivering comprehensive and innovative services. Entering into services can help you gain new understanding about your concerns and learn new ways of coping to allow you to achieve your goals. We are here to help.

Declaration of Values

Canadian Mental Health Association Huron Perth Addiction and Mental Health Services (CMHA HP AMHS) works within the Client Declaration of Values for Ontario:

Respect and Dignity – You have the right to be yourself and have your identity, feelings, and experiences valued.

Empathy and Compassion –You will be treated with empathy, kindness, and compassion, free from stigma and assumptions.

Accountability – You can expect that your care team will act with integrity and carry out their roles and responsibilities effectively.

Transparency – You have the right to make informed decisions about your care and your preferences will be at the center of all considerations.

Equity and Engagement – You will receive equal access to service regardless of language, place of origin, background, age, gender identity, sexual orientation, ability, marital or family status, education, ethnicity, race, religion, or socioeconomic status.

The full declaration created by the Patient and Family Advisory Council can be found here: https://www.ontario.ca/page/patient-declaration-values-ontario

Protecting our Client's Right to Privacy

At CMHA HP AMHS, we respect your right to privacy. Please read the following to better understand how we protect your privacy:

Obtaining the Consent of a Client:

While at CMHA HP AMHS, you will be asked to sign consent forms that will allow staff to speak with people that are part of your support circle. You have the right to choose to whom you would like to give consent to share your personal health information. In some cases, it is your right to refuse to provide consent; you also have the right to revoke consent. There may be times when you are not comfortable sharing all the details; you can choose to 'lock' certain parts of your personal health information as described in the Personal Health Information Protection Act (PHIPA).

Responding to police or court request of information:
There may be a time when police or an officer of the court (e.g. lawyer) request personal health information about you. In the event that a warrant or subpoena is issued for your records, CMHA HP AMHS is legally bound to provide information. CMHA HP AMHS may seek legal advice on this matter if there is any uncertainty about the request.

Prevent unauthorized access to all types of client information:
CMHA HP AMHS uses closed servers and protected databases for storing client information. CMHA HP AMHS also keeps all client information in locked areas.

System to track client's withdrawal of consent:
In the event that you rescind or revoke consent, your support person will make a note in your record and void the consent form.

Notifying clients in the case of unauthorized theft, loss, access, use or disclosure of client information:
You will be notified either by mail or at your next appointment in the case of unauthorized theft, loss, access, use of disclosure or client information.

Please feel free to ask your support person any questions or concerns you may have pertaining to your right to privacy.

How to Access your Record

- Clients are able to access a copy of their record for review within 30 days of request (or 60 days in the case of complex searches).
- Clients can request a correction of information or obtain a copy of their record.
- Clients must be aware that CMHA HP AMHS is unable to release any third party information held in the file.
- Clients can request assistance in interpreting their record.

CMHA HP AMHS's Privacy Officer is Catherine Hardman, CEO of CMHA HP AMHS. Her contact number is 519-271-6819, extension #201 and her email is catherine.hardman@cmhahuronperth.com.

How to Make a Complaint

If any aspect of your experience with CMHA HP AMHS has not been satisfactory, we welcome this feedback so that we cannot only address the concern but also improve future service. Complaints are handled by a member of the leadership team and will receive a response within 2 working days of the receipt, with resolution being offered within 10 working days. Complaints can be made by asking to speak with a member of the management team or via suggestion boxes at our offices, the CMHA HP AMHS website, by mail or email.

Right to Refuse Service

All services offered by CMHA HP AMHS are voluntary. Any client can refuse to participate in services offered by CMHA HP AMHS at any time. The client can notify CMHA HP AMHS verbally or in writing of their decision to withdraw from services. Upon receipt of notification, CMHA HP AMHS will begin the process to discharge the client from services which also includes voiding all CMHA HP AMHS consent to release personal health information forms. This process will be completed within 2 weeks of being notified of the client's refusal to participate in services.

If a client has been away from CMHA HP AMHS services for a period of 90 days, their file will also be discharged similar to the process described in the above paragraph.

Anyone is welcome to contact CMHA HP AMHS and re-engage in services at any time.

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Client Agreement

I, _____,
(name of client & date of birth)

have read and/or have had the following information read to me, and understand:

_____ Declaration of Values

_____ Protecting our Client's Right to Privacy

_____ How to Access your Record

_____ How to Make a Complaint

_____ Right to Refuse Service

(Please initial next to each item)

Before giving your consent for support and services, it is important that you are informed of possible risks and benefits of receiving services.

Potential Risks:

- Discomfort talking about personal thoughts and feelings
- Bringing up unpleasant or painful memories, situations, or events
- Recognizing that sometimes things can get worse before they get better

Potential Benefits:

- Increased ability to set and accomplish goals
- Improved coping, problem-solving, and communication skills
- Increased insight and understanding of self and others
- Personal empowerment and growth

I understand my client rights and responsibilities, as well as the potential risks and benefits of engaging in services with Canadian Mental Health Association Huron Perth Addiction and Mental Health Services.

Client Name (please print)	Client Signature
Staff Signature	Date

Canadian Mental Health Association
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Client Confidentiality

Canadian Mental Health Association Huron Perth Addiction and Mental Health Services understands the importance of confidentiality and wants you to know that information given by you will not leave the agency without your consent, except under the following conditions:

1. When a client is threatening to harm themselves or others, the appropriate authorities will be contacted (e.g. family physician, police or family member).
2. When a child under the age of 18 is considered at risk, staff will contact the Children's Aid Society.
3. When the records are subpoenaed by the court or when a search warrant is presented by the police, records will be surrendered to the appropriate authorities.
4. In the case of a medical emergency, appropriate emergency services (e.g. ambulance) will be contacted, as well as your emergency contact on file.

Canadian Mental Health Association Huron Perth Addiction and Mental Health Services is a member of the Huron Perth Addiction and Mental Health Alliance. The Alliance partners are part of a care team that work together to ensure you receive the best possible support. Information may be shared among the Alliance member agencies you are involved with, as necessary to coordinate care.

Please select all Alliance partners you **ARE** comfortable with Canadian Mental Health Association Huron Perth Addiction and Mental Health Services sharing information to coordinate care with:

☐ Alexandra Marine and General Hospital – Mental Health Services
☐ Canadian Mental Health Association Thames Valley Addiction and Mental Health Services
☐ Huron Perth Centre for Children and Youth
☐ Huron Perth Healthcare Alliance – Mental Health Services

I understand confidentiality and the limits of confidentiality.

Client Name (please print)	Client Signature
Staff Signature	Date

10 Downie Street, Suite 300 - Stratford, Ontario, N5A 7K4
Phone (519) 271-6819 or 1-888-261-9350 ● Fax (519) 271-2746 ● Email: support@cmhahuronperth.com ●
www.cmhahuronperth.com

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Consent to the Exchange of Personal Health Information

I, _____
(name of client & date of birth)

understand that at times it is helpful for the staff at Canadian Mental Health Association Huron Perth Addiction and Mental Health Services to share written and/or verbal information about me with other service providers/individuals when planning, providing and evaluating services.

I give my consent for the exchange of information between Canadian Mental Health Association Huron Perth Addiction and Mental Health Services and the following service provider/ individuals:

- ☐ Primary Care Provider: _____
  (e.g. Family Doctor, Nurse Practitioner, Registered Nurse)
- ☐ Psychiatrist / Psychologist: _____
- ☐ Family / Friends: _____
- ☐ Children's Aid Society: _____
- ☐ Probation or Parole Services: _____
- ☐ Other: _____

I understand that I can withdraw my consent at any time by notifying staff.

I understand that consents are valid until my file is closed, unless otherwise specified.

Consent to collect, use, and share my personal health information and the reason for personal health information sharing has been explained to me. I understand and give my consent.

Client Name (please print)	Client Signature
Staff Signature	Date

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Consent to Electronic Communication

I, _____,
(name of client & date of birth)

wish to communicate with Canadian Mental Health Association Huron Perth Addiction and Mental Health Services through text messages, email and/or video conferencing.

I give my consent to be contacted through the following methods:

☐ I **AGREE** that Canadian Mental Health Association Huron Perth Addiction and Mental Health Services may communicate with me through the use of text messages.

☐ I **AGREE** that Canadian Mental Health Association Huron Perth Addiction and Mental Health Services may communicate with me through the use of email.

☐ I **AGREE** that Canadian Mental Health Association Huron Perth Addiction and Mental Health Services may communicate with me through the use of video conferencing.

Canadian Mental Health Association Huron Perth Addiction and Mental Health Services strives to keep your information confidential. Communicating Personal Health Information through texting, email and/or video conferencing has potential risks which can include communication being received or intercepted by unintended recipients and/or recipients forwarding the information without Canadian Mental Health Association Huron Perth Addiction and Mental Health Services or client permission. With your permission, we will also email documents to a third party (e.g. residential treatment facility).

I have been advised by Canadian Mental Health Association Huron Perth Addiction and Mental Health Services that this is not a secure means of communication and accept the risks.

Client Name (please print)	Client Signature
Staff Signature	Date

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Client Privacy Agreement

Canadian Mental Health Association Huron Perth Addiction and Mental Health Services understands the importance of privacy and want you to know where your information is stored and shared.

Within the agency, your file is kept in secure electronic file systems and only staff members of the agency have access to these files. Client information is entered into the agency database, which is linked to a central provincial database. Although identifying information is transmitted, this information is not used. Other information is used for statistical purposes only.

Your file may be randomly audited for accreditation and training purposes.
I AGREE to my file being audited _____ (client initials)

You may be contacted during your care or after your file is closed to complete a survey.
I AGREE to be contacted about my client experience _____ (client initials)

Your information may be shared with trusted third-party sites—such as Electronic Medical Records Software within the Community Withdrawal Management programs—to track progress, plan treatment, and measure outcomes as part of your care plan with community partners.
I AGREE to my information being shared _____ (client initials)

I have read the above information and understand where my personal information is being stored and how it is shared.

Client Name (please print)	Client Signature
Staff Signature	Date

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